MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-C)

05996

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Illinois County:
City or town: Chicago
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5500 W. School St. Chi
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2 ✓

3.(a) FULL NAME: Bogdanoff, Leonard Dobry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-26-22

8. AGE: Years	Months	Days	If less than one day
22	9	2	hrs. min.

9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: Sgt. USMC
11. Industry or business

FATHER
12. Name: Dobry Bogdanoff
13. Birthplace: Illinois

MOTHER
14. Maiden name: - - - -
15. Birthplace: - - - -

16. Informant: Health Record, U.S.Navy
Address

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: 6/25/45 (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: U.S. Navy
Address: Indian Head, Md.

19. 6/25 19 45 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 June 1945 19 at M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 24 June 1945 19 to 19
and that I last saw h alive on Dead on arrival 19

Immediate cause of death	DURATION
Fractured skull	
Ruptured lung, multiple	
Due to fractures	
Due to Auto accident	minutes
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6-24-45
Where did injury occur? Indian Head (City or town) Charles (County) Md. (State)
Injured at home, farm, industry, public place (where?): State Rd.
Means of injury: Hit by Truck Injured at work? No

23. SIGNATURE: James L. MacKavanagh, M.D., Dep. Med. Examiner
Dr. MacKavanaugh M. D. or other
Address: Lapla, Md. Date signed: 6-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

65997

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Charles

City or town White Plains

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Charles Angelo Fenwick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S.

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9 - 2 - 44

8. AGE: Years ..... Months 6 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace Charles

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name Dudley Fenwick

FATHER 13. Birthplace Billingsley, Md.

MOTHER 14. Maiden name Carrie Pike

MOTHER 15. Birthplace Pomfret, Md.

18. Informant .....

Address .....

17. Burial. Date thereof 6 / 6 / 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's

Location Pomfret, Md

18. Funeral director Rev. Hugh A. Dalton S.J.

Address La Plata, Md

19. ..... 19..... .....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 4 19 45 at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 - 8 19 45 to 6 - 4 19 45

and that I last saw h[illegible] alive on 6 - 4 19 45

Immediate cause of death	DURATION
Friedlanders Pneumonitis	5-8-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. B. Allen M.D.

M. D. or other

Address La Plata, Md. Date signed 6-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05998

Reg. Dist. No. 106

1. PLACE OF DEATH:

County: Charles County

City or town: NRF, Indian Head, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 PM. 6-15-45.

Hospital, institution, or street address where death occurred:

New Dock, Naval Pow. Fac. Indian Head, Md.

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Montgomery

City or town: Glenside, Penna.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 W. Glenside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World Ward No. II ✓

3.(a) FULL NAME: GREGER, Joseph George

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
26	10	12	hrs. min.

9. Birthplace: Edge Hill, Penna (Town, county, and state)

10. Usual occupation: Ho.M2c. USCG

11. Industry or business: Coast Guard

FATHER — 12. Name: Deceased

13. Birthplace:

MOTHER — 14. Maiden name: Grace Greger

15. Birthplace:

16. Informant: Taken from Service Health Record.

Address:

17. res mk (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Naval Coast Guard

Address: Indian Head, Md.

19. 6/16 1945 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-16-45 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-16-45 19..... to ..... 19.....

and that I last saw h... alive on Dead on arrival 19.....

Immediate cause of death	DURATION
Asphyxia, by drowning	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6-16-45

Where did injury occur? Indian Head, Chas. Co., Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Drowning Injured at work?

23. SIGNATURE: R. Volk

R. VOLK, Lieut. Comdr. (MC) USNR

M. D. or other

Address: Indian Head, Maryland Date signed: 6-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B/a)

05999

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County ~~Country~~ Charles
City or town Potomac Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Potomac Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosa Ellen Kremer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Herbert F. Kremer
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Jan 18 1900

8. AGE: Years	Months	Days	If less than one day
45	5	10	hrs. min.

9. Birthplace Maurertown Shenandoah Co. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name Austin K. Conner
13. Birthplace Star Tannery, Virginia.
14. MOTHER Maiden name Mary E. Smoot
15. Birthplace Harrisville Virginia
16. Informant Herbert Kremer
Address Potomac Heights
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2 1945 (month) (day) (year)
Cemetery or crematory Harrisville Cemetery
Location Harrisville Va.
18. Funeral director Hunt & Pyous
Address Waldorf Md.
19. 6/29 1945 Edey Brise
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1945, at 10 35 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1935, to June 28 1945
and that I last saw h. alive on June 27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Cardio-renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. C. Bicknell M.D.
M. D. or other
Address Marlboro Md Date signed June 29

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

56000

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Wicomico
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En route

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth ~~Gross~~ Mason

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Albert ~~Gross~~ Mason

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb, 1910

8. AGE: Years: 35 | Months: 4 | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: La Plata Charles, Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: James Smith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Hawkins
15. Birthplace: St. Mary Co., Md.

16. Informant: Dorothy Mason
Address: La Plata, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7, 1945 (month) (day) (year)
Cemetery or crematory: Newtown Methodist
Location: Newtown, Md

18. Funeral director: Hewitt & Ryan
Address: Waldorf, Md

19. June 4 1945 (Date rec'd by registrar) Julia H. Pacey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3, 1945, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~on~~ June 3, 1945 to ____ 19____ and that I ~~saw her~~ last saw her alive on June 3, 1945

Immediate cause of death	DURATION
Fracture - dislocation of cervical spine	Seconds
Due to: Automobile accident	Seconds
Due to:	
Other conditions: Multiple fractures of extremities	Seconds

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6-3-45

Where did injury occur? Wicomico (City or town), Charles (County), Md (State)

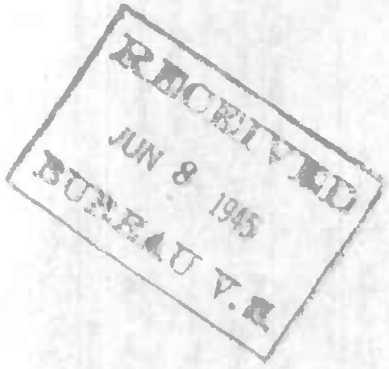
Injured at home, farm, industry, public place (where?): State Road

Means of injury: Auto turnover Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: James L. MacKenzie, M.D.
M. D. or other

Address: La Plata, Md Date signed 6-3-45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JUN 8 1945
BUREAU V.R.

06001

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

VS A15 (4) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:

County: Charles

City or town: Pomfret md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Chas

City or town: Pomfret md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Fannie E. Monroe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: Robert Monroe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 23 - 1879

8. AGE:

Years	Months	Days	If less than one day
66	1	30	..... hrs. ..... min.

9. Birthplace: Charles Co (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Richard A. Rabey

13. Birthplace: Chas Co Md

MOTHER — 14. Maiden name: mary m monroe

15. Birthplace: Chas Co Md

16. Informant: Gertrude Cox

Address: Pomfret Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-45 (month) (day) (year)

Cemetery or crematory: St Pauls Piney

Location: Waldorf Md

18. Funeral director: Hamill & Ryon

Address: Waldorf Md

19. 6-22-45 (Date rec'd by registrar) M. C. Groves Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945, at 3-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1945, to June 21 1945

and that I last saw h. C.P. alive on June 22 1945

Immediate cause of death	DURATION
Cancer of Uterus	5-16-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Fedelen M.D. M. D. or other

Address: LaPlata Md Date signed 6-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06002

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Indian Head

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 120 Cogswell Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Poe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith M. Johnson

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Febr. 5, 1889

8. AGE:

Years	Months	Days	If less than one day
56			...hrs. ...min.

9. Birthplace: St. Mary's County, Md. (Town, county, and state)

10. Usual occupation: Oyster & Fisherman

11. Industry or business:

FATHER

12. Name: George Poe

13. Birthplace: St. George Island, Md.

MOTHER

14. Maiden name: Mamie Potter

15. Birthplace: St. George Island, Md.

16. Informant: Mrs. William Wood

Address: 120 Cogswell Ave, Indian Head Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-22-45 (month) (day) (year)

Cemetery or crematory: St. Francis Xavier

Location: St Georges Island Md

18. Funeral director: W.C. Mattingley Sons

Address: Leonardtown, Md.

19. 6/19 19 45 Julia H. Posey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 1945 to June 19, 1945 and that I last saw h... alive on June 19, 1945

	DURATION
Immediate cause of death: Congestive heart failure	3 months
Due to: Essential hypertension	10 yrs.
Due to:	
Other conditions: Chronic glaucoma	20 yrs.
Peripheral arteriolar spasm (Include pregnancy within 3 months of death)	1 yr.

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

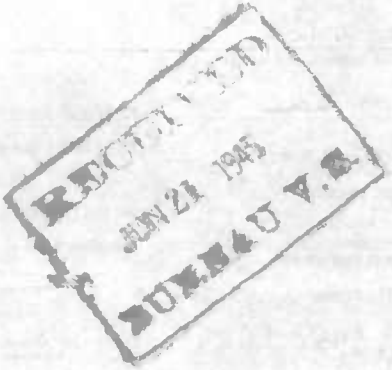
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. MacKavanagh, M.D. (M. D. or other)

Address: La Plata, Md. Date signed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JUN 21 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

06003

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Charles
City or town: Waldorf md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cecil Ann Proctor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F ~~M~~	C	Wid

6.(b) Name of husband or wife: Walter J Proctor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1858

8. AGE:

Years	Months	Days	If less than one day
86			..... hrs. ..... min.

9. Birthplace: Charles Co md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Francis Swan
13. Birthplace: Charles Co

MOTHER
14. Maiden name: Cecil Thompson
15. Birthplace: Charles Co md

16. Informant: Reed Proctor
Address: Waldorf md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-45 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waldorf md

18. Funeral director: Smith & Ryon
Address: Waldorf md

19. 6-22 (Date rec'd by registrar) 19 45 M S Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 19 45, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~June~~ on June 22, 19 45, to ~~June~~ 19 ; and that I ~~last saw~~ saw her ~~alive~~ on June 22, 19 45

Immediate cause of death: Generalized arteriosclerosis — DURATION: 5 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dep. Med. Examiner John L MacKenzie, M.D. M. D. or other
Address: Sub Station, Md Date signed 6-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 06004

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Bel alton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: Charles
City or town: Bel alton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Short

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Widowed

6.(b) Name of husband or wife: Lucy (Deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? 1870

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Bel alton Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Westinmon
13. Birthplace: Bel alton Md

MOTHER
14. Maiden name: Theresa ?
15. Birthplace: Bel alton md

16. Informant: Joseph Short Son
Address: Bel alton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9-45 (month) (day) (year)
Cemetery or crematory: St Thomas
Location: Bel alton Md

18. Funeral director: Hewitt & Ryon
Address: Waldorf Md

19. 6/9 (Date rec'd by registrar) 19 45 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 19 45 at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 43, to June 6 19 45 and that I last saw him alive on June 5 19 45

Immediate cause of death	DURATION
Chr. Myocarditis	10 yrs
Chr. Nephritis	7 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none performed
Date of op.
Autopsy results: none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Ernest Spence M.D.
M. D. or other
Address: Bel alton Md. Date signed 6-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

06005

★ 105

Reg. Dist. No. .....

1. PLACE OF DEATH
County: Charles
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: So. Car. County:
City or town: Mullins
(If outside city or town limits, write RURAL and give nearest town)
Street No. 762 Dixon St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Leon Singleton
3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife: Earenge Singleton
6.(c) If alive, give age: 35 years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
37			..... hrs. ..... min.

9. Birthplace: Marion S C (Town, county, and state)
10. Usual occupation: Day Laborer
11. Industry or business: Tobacco
FATHER 12. Name: Samuel Singleton
FATHER 13. Birthplace: Marion S. C.
MOTHER 14. Maiden name: Minnie Singleton Crawford
MOTHER 15. Birthplace: Marion S C
16. Informant: Minnie Singleton
Address: Mullins S C
17. Burial: Date thereof 6 10 45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cedar
Location: Mullins S.C.
18. Funeral director: Hunter & Lyon
Address: Darby Pa
19. 6-7 19 45 M. L. Moore (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-6 19 45 at 8 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Chronic's Case 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Acute Alcohol — DURATION: 6-6-45
Due to: Poisoning
Due to: Iso-propyl Bathing Compound
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hedden M. D. (M. D. or other)
Address: Ft Pleasant Date signed 6-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06006

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary Indiana Yates

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. S. Yates.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 12. 1865

8. AGE:	Years	Months	Days	If less than one day
	79	5	29	..... hrs. ..... min.

9. Birthplace: Wicomico, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
12. Name of FATHER: John L. Budd
13. Birthplace of FATHER: New port. Md.
14. Maiden name of MOTHER: Mary E. Carpenter
15. Birthplace of MOTHER: St. Marys Co. Md.
16. Informant: Laura Yates
Address: Indian Head. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12. 1945 (month) (day) (year)
Cemetery or crematory: Sacred Heart Catholic
Location: La Plata, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf. Md.
19. 6/11 1945 Odey Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945 at 3-50 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1945 to June 9 1945
and that I last saw her alive on June 9 1945

Immediate cause of death	DURATION
Coronary Embolism	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank L. Swann M.D. M. D. or other
Address: Indian Head. Md. Date signed 6/9/45